NHS
North East
Ambulance Service
NHS Foundation Trust

Strictly Private and Confidential
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Date: 26 January 2023

Dear Mrs Henley,

Inquest into the death of Joan Ferguson

Regulation 28 – Report to prevent future deaths

I am writing in my role as Chief Executive of North East Ambulance Service NHS Foundation Trust ("NEAS") and in response to the Regulation 28 report for the prevention of future deaths dated 17 December 2022 as issued by you following the inquest into the tragic death of Joan Ferguson.

The matters of concern listed in your report are: -

1. During the course of the inquest I heard evidence from the Health and Safety Manager at NEAS. He accepted that a risk assessment should have been carried out prior to every transfer conducted in respect of a complex bariatric patient. Joan was a complex bariatric patient and yet received no up to date risk assessment. He stated that this risk assessment should have been carried out by a Scheduled Care Team Manager and should have included information taken from Joan and/or her family and/or clinicians involved in her care.

2. During the course of the inquest and investigation, the family provided information that Joan had fallen on three or four earlier occasions during hospital transfers. NEAS have no record of these incidents. I accept the family's account and am concerned that no records were made of these incidents. The absence of recorded incidents prevented an accurate risk assessment taking place.

3. During the course of the inquest and investigation, I heard evidence from the Health and Safety Manager that a dynamic risk assessment should have been conducted during the transfer. I heard evidence from the Clinical Support Assistant who should have received effective training on dynamic risk assessment. There was no evidence that he performed an effective dynamic risk assessment on 3.5.22.

4. During the course of the inquest, the three members of NEAS who effected Joan's transfer on 3.5.22 each gave evidence. They each accepted that they did not ask Joan and/or did not wait for a response from her, did not ask ward staff prior to leaving hospital and did not ask Joan's husband who was in the vicinity of her home, prior to them encouraging Joan to stand, whether she was able to stand safely. Instead, they relied on historical information and encouraged her to stand.

You will note that we have removed the names of the Trust witnesses from our letter of response and simply use their position. I hope that this is appropriate in considering the response will potentially be published via the Ministry of Justice website.

We will address each point you have raised in your matters of concern below: -

1. **During the course of the inquest I heard evidence from the Health and Safety Manager at NEAS. He accepted that a risk assessment should have been carried out prior to every transfer conducted in respect of a complex bariatric patient. Joan was a complex bariatric patient and yet received no up to date risk assessment. He stated that this risk assessment should have been carried out by a Scheduled Care Team Manager and should have included information taken from Joan and/or her family and/or clinicians involved in her care.**

   The 'Care and Transportation of Bariatric and Complex Patients' procedure has been updated to provide more robust processes to prevent reoccurrence and strengthen the risk assessment process. This applies to those cases classified as 'patients with complex needs and those deemed as bariatric or require complex extrication'.

   The following details are an extract from the enclosed 'Care and Transportation of Bariatric and Complex Patients' procedure.

   'In the case of a planned journey for Scheduled Care, a risk assessment must be carried out prior to the actual journey taking place. This is to identify any potential risks and obstacles that may be present and gives time to call in additional help/support or involvement from other agencies. If the patient has previously travelled, this can initially be done over the telephone. The Scheduled Care Team Manager should ascertain whether any of the previous risk assessment details have changed and if so, arrange a face to face assessment'.

   'Scheduled Care pre-planned journeys should be booked at least 48 hours in advance, risk-assessed by a Scheduled Care Team Manager with input from a Clinical Support Assistant is required, documented on the correct form (Patient Moving Handling Risk Assessment Form & Plan) and sent electronically to the special patient notes team (special.patient.notes@nhs.net) and Patient Transport Service Dispatch Support. If a request is made with less than 48 hours' notice, Patient Transport Service Dispatch Support must make contact with a Team Manager via telephone to ascertain if it is possible for the assessment to be carried out'.

   'On receipt of a planned journey of a known or suspected bariatric or complex patient, the Emergency Operations Centre will take the booking via the Scheduled Care booking process and then inform Patient Transport Service Dispatch Support who will request the assessment is undertaken by contacting the Scheduled Care Team Manager. Patient Transport Service Dispatch Support will provide as much relevant information as possible to allow the Team Manager to carry out the assessment'.

'The Scheduled Care Team Manager will contact the patient or person who requested the assessment and arrange a suitable time to attend. If the Team Manager feels specialist input is required, then they must make contact and arrange this. Once the assessment has been carried out, the Team Manager/ Clinical Support Assistant *will complete the relevant documentation (Patient Moving Handling Risk Assessment Form & Plan) and send this back to Special Patient Notes and Patient Transport Service Dispatch Support'.*

'The Special Patient Notes Team will place any relevant flags in all Cleric systems prior to the journey being undertaken. The Patient Transport Service Dispatch Support team will add notes to any live bookings'.

The 'Care and Transportation of Bariatric and Complex Patients' procedure is enclosed to provide full details of the updated procedure. The procedure does cross into the other concerns raised within the Prevention of Future Deaths (Regulation 28) Report.

2. **During the course of the inquest and investigation, the family provided information that Joan had fallen on three or four earlier occasions during hospital transfers. NEAS have no record of these incidents. I accept the family's account and am concerned that no records were made of these incidents. The absence of recorded incidents prevented an accurate risk assessment taking place.**

Internal investigations have not identified any reported incidents prior to the incident associated with the case. We have spoken with internal and external partners to try and identify any incidents. Upon checking the integrated risk management system (Ulysses) we have not found any additional records except historic safeguarding referrals which generated the original risk assessment. We cannot find any records of previously reported incidents or complaints/concerns raised by our crews/staff.

The only information we have sourced is from the Investigating Officer who undertook the internal investigation into the specific incident. As you know the Investigating Officer was not able to attend the inquest due to unforeseen circumstances and with your permission another witness took their place. We acknowledge this was not ideal nor helpful to the inquest and those involved.

The Investigating Officer re-calls that a member of the EVAC team had advised Joan had mentioned a previous fall. It was explained that this occurred when Joan was more mobile and living upstairs. The member of staff has advised that Joan suggested the fall had occurred when going down the house stairs but could not recollect more about it, including date, time and circumstances. It is understood it was likely before 2020 but we have not identified any information or evidence during our inquiries. This did not form part of the investigation report as we could not identify if the fall had occurred during one of our attendances to Joan.

External inquiries have included speaking with third party providers which reached the same conclusion with no incidents been reported or recorded. Internal inquiries extended to reviewing bookings for Scheduled Care transport and emergency calls involving our Unscheduled Care crews. Upon reviewing the case notes on each case/attendance, we have not identified any records to indicate a fall or 'dropping' of Joan.

Due to our inability to identify any historic incidents, we will approach the family to ask if they are able to help with further details/information. It is however important to note that during our original investigation and liaison with the family, no previous incidents were disclosed. The same applies to the inquest, during evidence the family intimated previous incidents when Joan was dropped, however no details were provided.

In respect to the point 'the absence of recorded incidents prevented an accurate risk assessment taking place'. Whilst we acknowledge that information regarding previous incidents is important to assist with risk assessments, it is important to draw upon the response below. The fact that our staff had not spoken with hospital staff, Joan's family and Joan is a key factor in the effectiveness of the dynamic risk assessment. As heard during the inquest evidence provided by the Trust's Health and Safety Manager, dynamic risk assessment was explained as ***"merely a thought process when things change, and you think on your feet, and you might need to change process or put a new risk control measure in place to do something safely".***

In considering a planned risk assessment, then previous incidents would certainly be a key consideration to help formulate effective control measures. We refer onto the 'Care and Transportation of Bariatric and Complex Patients' procedure for more information in this regard.

3. **During the course of the inquest and investigation, I heard evidence from the Health and Safety Manager that a dynamic risk assessment should have been conducted during the transfer. I heard evidence from the Clinical Support Assistant who should have received effective training on dynamic risk assessment. There was no evidence that he performed an effective dynamic risk assessment on 3.5.22.**

Whilst the crew did undertake a dynamic risk assessment our own internal investigation concluded that they had not established any changes in mobility. This included not seeking information from hospital staff or the patient's family. This fundamentally flawed the quality of the dynamic risk assessment which was therefore based on previous experience and without clear communication with the patient.

We can confirm that our operational staff receive dynamic risk assessment training as part of statutory and mandatory training and other specific information, instruction, and training. In this case the main issues related to the lack of communication/information with hospital staff, Joan's family and indeed Joan. This factor is linked with the fact the planned risk assessment had not been re-visited in a timely manner and the wider compliance with existing procedures. These factors are addressed within the responses for the related concerns raised within the Prevention of Future Deaths (Regulation 28) Report.

In addition, we can confirm, as per our serious incident investigation report, that information has been shared with staff in respect to communication, before and during dynamic risk assessments.

4. **During the course of the inquest, the three members of NEAS who effected Joan's transfer on 3.5.22 each gave evidence. They each accepted that they did not ask Joan and/or did not wait for a response from her, did not ask ward staff prior to leaving hospital and did not ask Joan's husband who was in the vicinity of her home, prior to them encouraging Joan to stand, whether she was able to stand safely. Instead, they relied on historical information and encouraged her to stand.**

   This point is directly linked with the previous concerns and our responses. I will not repeat the information previously detailed and that contained within the enclosure. We would however like to acknowledge that this point was identified within the internal investigation report and added into the recommendations/action plan. We can therefore confirm that the importance of communication with partners, those involved in the care, families and patients has been shared with our staff as a reminder.

   These factors and others will be monitored via our adverse incident reporting and investigation processes, equally important is the learning outcomes from such adverse events. Work is on-going to strengthen internal processes to ensure the triangulation of information and intelligence to help improve the experience, quality and safety of service services users.

I hope that this addresses the matters of concern which you have highlighted. [redacted]

Yours sincerely

[redacted]

[redacted]
Chief Executive

Enclosure